HEALTH FOR ALL BY THE YEAR 2000 :

PLANS, PROGRAMS AND OPTIONS FOR RURAL INDIA

A COLLOQUIUM HELD ON

NOVEMBER 26, 1983

SPONSORED BY :

USAID / NEW DELHI

HEALTH FOR ALL BY THE YEAR 2000:
PLANS, PROGRAMS AND OPTIONS FOR RURAL INDIA *

A. Summary and Recommendations

The presentations and discussion during the one-day colloquium on Rural Health encompassed a number of themes, often interlinking them. These are briefly presented below. Further details are given in part B of this report.

1. Community involvement in health care was considered most desirable by all. Two complementary aspects were discussed : first, that of making health programs relevant to the Indian rural "cultural context" to make them people's programs; secondly, that of mobilizing and utilizing resources available in the "community", such as local women for primary health work, village organizations for health and development activity, and people's participation in decision-making. Cooperation among communities (villages) was also discussed. It was recognized that the government health system must find ways to increase community participation (for which some suggestions are given in points 2 and 5).

2. Health education was labelled the key to community involvement and to better health, both for the assumption of responsibility by people for their own health, and for their realization of their right to certain health services, or "creation of demand". Also referred to as "health modernity education" and "raising health consciousness", the focus was on the need to change the attitudes of people towards prevention of ill-health, increase

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confidence and action for health improvement, and rational use of curative services (i.e. to reorient "demand" from curative to preventive care). The value of person-to-person motivation was stressed, and was illustrated in the 'case history' of Jamkhed. Much of this, it was felt, could and should be undertaken by government.

3. Women were considered to be the key agents of transmitting health both as central family members on whom health programs should be targetted, as well as health service deliverers. The need for, the scope and the requirements of women healthworkers (CHVs, dais, MPWs, AWWs, etc.) were discussed. There was concensus on the need to utilize the vast potential for educating village women in and for health, which was brought out in the presentations of Shahaji and Dr. Antia. The presentation by Dr. Ruth Harnar focussed attention on the problems and prospects of nurses.

4. Several aspects of health administration were dwelt upon. Considered of major importance was the need to reorient health professionals from "cure to care", changing attitudes to basic health workers, redefining roles to engender team work, and redistributing skills in accordance with a primary health care-cum-referral strategy. Decentralization, decreased dependency on doctors, and use of "alternative" personnel were suggested ideals. The fact that primary health care is inadequately taught in medical colleges was brought out. The need to improve health service functioning, accountability and utilization was linked to the lack of training in management and organization as part of medical education or specifically for personnel in the government health services. Combining training and practice of management both for trainers and practitioners was seen as a way to increase appreciation of the need for

management and to enhance the effectiveness of training. This was the focus of Mr. Ashok Subramaniam's presentation. A specific recommendation was made to set up regional management training centers. Implicit in these discussions was the view that health planning must give precedence to the rural health sector over the urban, and the spread of administrative changes throughout the country was considered a requirement for Health For All.

5. The role of voluntary health organizations was the subject of Dr. Visaria's presentation and was repeatedly examined in discussion. It was felt that the government system could learn much from the experience of VO's, especially with regard to health education strategies and community participation in health care. It was suggested that government could learn from non-governmental efforts also about alternative strategies, intersectoral action, and evaluation (see points 8 and 9 below). The consensus that learning and "transfer of experience" by assimilation into the larger government system of "techniques and modalities" developed by the voluntary sector is more feasible than "replication" emerged during discussions. VO's were viewed as the "bridge" between rural and urban areas but it was not discussed whether the government system could avail of their auspices tochange the urban-orientation of medical graduates to rural communityhealth service. A scheme could be devised for suitably-placed VO's to take a greater role in the process of re-orienting government health personnel and it was suggested that donor agencies can assist VO's and government to train people for community service and organization. However, a caution about government-non-government interaction was sounded in a mention of the scheme to hand over a district to VO's, which has met little success thus far.

6. The need to spread through the rural health system critical/ useful appropriate technologies (such as ORS, use of life-saving injections, sterile delivery kits) which are available at the institutional level, and have been tested in pilot programs (often by non-governmental agencies) was clearly brought out in the presentations by Drs. Mahajan and Vijay Kumar. Increasing their availability at the village-level at low or no cost, by simplification and through use of village health workers was the key point, though larger-scale testing in the government system was considered desirable in some instances. It was suggested that this could be done in the districts covered bythe area programs supported by several donor agencies.

7. The reorientation of research to service delivery was discussed. Operations research was considered paramount, i.e., the need to work out in field situations solutions to specific health care problems or to test available technologies. The experience of VO's while valuable needs to be confirmed on a larger scale in the government health system, utilizing the latter's personnel and infrastructure. Communication and training strategies, management, logistics and supply, and cost-effectiveness of health services are also subjects for operations research. Such health services research should be done by the system itself so that outcomes are measured under its particular conditions and so that results ae spread effectively.

Two recommendations were made for interdisciplinary research studies : (1) on the antecedents, causes and consequences of infant and child morbidity and mortality; and (2) on non-health factors influencing health. These studies were seen to provide scope for interaction between voluntary organizations, government and health professionals and it was suggested that their findings would provide insights for program design and could be used for health education. Peoples participation in research was discussed as a means to make it "need based."

8. The importance of non-health factors for rural health was stressed. Discussion ranged from the issue of provision of basic needs through specific programs, to overall socio-economic development. Efforts of voluntary organizations to do 'health and development' work simultaneously were cited and similar intersectoral action by government agencies was considered desirable. There is a need for better coordination between government programs (e.g. ICDS and health). The use of existing village development organizations to do health work was suggested. Mention was also made of the 'ill-health' effects of socio-economic development which must be overcome by proper health education. The converse role of health in bringing about socio-economic development was pointed out.

9. There was little substantive discussion on the subject of evaluation but some specific separate suggestions were made : (1) A performance-oriented assessment of government health personnel with a suitably-devised reward system. (2) Objective evaluation of effectiveness of the existing primary health center system. (3) Measurement of the cost-effectiveness of alternative health technologies and strategies. More broadly, the use of cost-benefit analysis to advocate larger allocations to health was suggested. (4) The need for the government health system to inculcate the kind of community-oriented feedback system of health information used by VO's both to increase awareness of health problems among the people as well as to check on the performance of the delivery system.

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In sum, the seminar concentrated on the "soft" aspects of rural health care - the necessary ingredients for qualitative and effective health service provision - rather than on the "hardware" that has preoccupied health planners and policy-makers in the past. A central issue was the quality of health personnel, their skills and attitude training, particularly for their proper interaction with "communities". Of equal importance was the concern for generating health action within village communities. The formulation of strategies to do this, and to improve the response of the health service infrastructure is seen as the key to Health For All.

B. Report of the Colloquium

Mr. Owen Cylke, Director, USAID, welcomed the participants tothe informal meeting intended to enable donor agencies to interact with Indian health professionals. He expressed an interest in some specific issues : (1) the importance for government programs of village-level efforts in health, (2) non-health factors determining health status, and (3) evaluation systems.

Mr. C.R. Vaidyanathan, Secretary, Ministry of Health and Family Welfare, inaugurated the seminar expressing the hope that the participants would present their views on health care and the scope for improving health administration, which might be useful in the ongoing formulation of the VII Plan. He referred to the country's achievements in health over the past 30 years, the Alma Ata declaration, and the National Health Policy which has definite goals for Health for All by the year 2000. He stressed the need for "health modernity education", community involvement and targetting of programs on women "to ensure proper health care for the whole family".

Dr. A. Zahra, WHO Program Coordinator, spoke of the need to concentrate on delivery of health services to the homes of the "many" in rural India, and to view health in the context of socio-economic development. He said this process had begun with the VI Five Year Plan and the institution of the Community Health Volunteers and Multi-Purpose Workers Schemes. He viewed the three "cornerstones" of primary health care as community involvement, intersectoral action and appropriate technology, and stressed their importance in the VII Five Year Plan.

Dr. Harcharan Singh, Joint Advisor, Health, Planning Commission, spoke on the subject of Planning for Health for All by the year 2000, particularly for rural areas. In his view, the change in focus of the health services from "cure to care" has been the most significant improvement in the recent past. While cautioning against underrating India's achievements in health, he saw the present challenge as that of spreading health throughout the country. There are ten important factors on which this will depend - five "P's" - political will, professional attitudes, peoples participation, private sector motives and press publicity (i.e. information, education and communication); and five "M's" men, money, materials, means and methods.

He discussed the decline in allocations to health (and low proportion to rural health) over the past six five year plans and the need for health professionals to talk in terms of cost benefit. He stressed the need to create demand for health (health consciousness) and to meet this demand with functional programs. Changes in professional attitudes toward the CHV, better skills training and managerial methods at the PHC level, and performance-oriented evaluation with a reward system are required, he said. He cited the possibility of learning from ongoing health experiments, particularly about community involvement.

The next presentation was by Shri Shahaji Bhondve from Ghudegaon, Jamkhed, who described the development of health in his village over the past twelve years, beginning with the formation of a Farmers Club and Womens Club in 1971. Initially there was a mobile medical team which the village people found unsatisfactory. They therefore requested Dr. Arole to train a woman from their village. She has in turn educated the people about prevention of guinea worm, malaria, typhoid, dysentery, about proper nutrition, treatment of fever, diarrhoea, snake-bite, etc. and provides antenatal and postnatal care. She is assisted by the Mahila Mandal and the Farmers Club which runs a supplementary feeding program for children. The village has also learned the importance of family planning and plans to have no delivery in 1985! Shahaji described a program of cooperation between 175 villages in the area. He concluded by saying that the people now have knowledge about health and therefore confidence in themselves. "(They) don't need Dr. Arole, now".

Dr. Visaria, Director, Gujarat Institute of Area Planning, Ahmedabad, discussed the evolution of voluntary effort with particular reference to Gujarat and to health VO's. He saw their role as one of bridging the rural-urban gap before government programs became effective. He described a few efforts in which urban based doctors had mobilized urban resources and delivered specific services in rural areas. He saw these as experiences in which the urban educated learned about traditional practices and thereby increased their credibility. He viewed favorably the prospects of coordinating and supplementing governments activities with those of voluntary groups, particularly in the area of "health modernity education" aimed at teaching people their roles and responsibilities in controlling their own health. He suggested three important topics on which VO's could play a significant role in educating the wider public: aseptic cord-cutting (to prevent neonatal tetanus), proper nutrition (e.g. to prevent night blindness) and diarrhoea control.

Dr. Visaria mentioned a need for inter-disciplinary researchon the antecedents, causes and consequences of infant and child mortality and morbidity. Education on this subject also provides scope for interaction between people, voluntary organizations and professionals. He also suggested a need to systematically identify linkages between socio-economic factors which influence health - which VO's do in the course of their people-oriented programs.

Dr. Visaria concluded by stating that VO's have neither a monopoly nor the capacity to cover the entire country but that there is scope for mobilizing their resources and their efforts to parallel government's.

The ensuing discussion raised several points :

1) Health and development are closely linked and VO's recognize this by dealing with basic needs of the community in addition to health needs. Existing village organizations can be utilized for health work combining it with socio-economic development. (Zahra, Harcharan Singh, Harnar).

2) One suggestion was to change medical education curriculum so that doctors have the managerial and organization skills to work in rural areas. However, other participants expressed the view that it was more important to generate health action at the village level rather than depend on doctors. Donor agencies can help voluntary organizations and government agencies to train health and development professionals for community service and to mobilize communities into action. (Arole, Visaria, H. Singh, Shahaji).

The next presentation was by Dr. N.H. Antia of the Foundation for Research in Community Health, Bombay. His main points were :

1) There is a need to work towards health for all within the cultural context of rural India, in personalized informal ways. "Intersectoral action" is alien to the culture and peoples participation" does not fit into a top-heavy health service structure. HFA must be a people's program with full administrative and financial control vested in the villages.

2) Health knowledge and technology can be simplified and village women can be trained to utilize it. However, the technical aspect of primary health care is small compared with the cultural component which is best delivered by village people themselves. In the field project conducted by FRCH, the targets set for 2000 A.D. were achieved within five years through village women!

3) Health is a low priority among the poor until illness prevents them from earning a living. There is a need to overcome the concept of health as equivalent to hospitals, doctors and injections which are provided to the middle class and to which village India aspires. Person to person motivation and health education are important factors to bring about attitudinal change.

4) We must utilize resources which are available among the people such as the Village Health Worker. Development groups working in the villages can piggy-bank health care, training VHWs and providing back up services. Health must be a "people's movement".

In discussion the following points were raised :

1) The fundamental contradiction between the diversity and flexibility of VO's and the standardized schemes of government makes replication a moot issue. The more important points are for government and others to learn from VO experience and to decentralize their approach to health care (Subramaniam, Nanavaty).

2) Education has a central place in health. Knowledge cannot be appropriated by the rich in rural areas who corner most other benefits (Antia).

Dr. D.B. Bisht, Director General of Health Services, made the next presentation. He spoke on several points that had been made earlier including : working with our cultural heritage, vesting responsibility for health in the people and not depending on doctors. The roles of functionaries are being discussed in the VII plan formulations. He spoke of the need to provide education, particularly to prevent the spread of harmful practices brought about through industrial 'development' and urban exploitation of rural areas. Much aid which assists these processes can be termed "ill health aid". Other aid has gone into bricks and mortar rather than into basic needs such as nutrition, water and sanitation. He spoke of Mahatma Gandhi's simple approach to health. He stressed the need to define the purpose of development and to identify goals for health in order to 'perfect the means' i.e. identify the functions of the health delivery system and allocate resources accordingly.

The following issues were raised in discussion :

1) It was clarified that we do not seek to reject the medical profession in the path to HFA but rather to decrease dependency on it, turning the vast majority of health tasks over to paramedics and the people. Doctors have a crucial role in the referral system required along with primary health care. (Jordan, H. Singh, Zahra, Antia, Bisht).

2) The teaching of primary health care in medical colleges is poor because the responsibility is given to departments of preventive and social medicine (which are weak) and as a result other specialty departments do not undertake it. There is a need to make all departments aware of primary health care (Kimati, Bisht, H. Singh).

3) The problem of who leads the health team is crucial - the best head for primary health care may be the ANM who operates at the sub-center level. (Walia, Bisht).

4) "Replication" of voluntary efforts can be confined to techniques and modalities because their infrastructure differs significantly from governments. Health service research is often not utilized because of program or policy constraints or "communication barriers" (H. Singh).

5) Peoples attitudes to health may be changed by the positive results of a program. A simple evaluation and feedback system within a community can help arouse consciousness and commitment, as demonstrated by some VO programs. The government system should do this (O'Byrne).

In conclusion of the morning session, Dr. Zahra pointed to the need to provide services which people want, where the people are, and to make health a people's movement.

The afternoon session was devoted to aspects of researchand training for rural health service delivery. It was chaired by Dr. Baori Saxena, Deputy Director-General, Indian Council of Medical Research.

Dr. R.C. Mahajan, Head, Department of Parasitology, Post Graduate Institute of Medical Education and Research, Chandigarh, gave a detailed account of clinical diagnostic technologies available for the country's most important diseases (malaria, gastro-intestinal infections, acute respiratory diseases, TB, Leprosy) and some regionally important ones. Laboratory services are useful in determining the epidemiologyof infection and its diagnosis for rural health services. Several simple and rapid diagnostic techniques are available for the common diseases, the most promising of which is the recently developed micro-ELISA technique. Methods for blood collection and transport have also been simplified. It is possible to train paramedical staff in these techniques, facilitating accurate diagnosis; but the problem of putting the technology into the health system throughout the country remains.

Dr. Vijay Kumar, Department of Community Medicine, PGIMER, Chandigarh, spoke on operational research for rural health, particularly that aimed against the major killer diseases. He used three examples to illustrate the gap between delivery and availability of technology and manpower. These were diarrhoeal disease, neonatal tetanus, and acute respiratory disease which are priority problems. Pilot experiments have shown that it is possible

to tackle these problems on a small scale but we do not have operational experience for the country as a whole despite the national importance of the problems, availability of technology, low cost of interventions, and their cultural acceptability. (The relevant technologies are oral rehydration, tetanus toxoid and sterile delivery kits, and penicillin injections, respectively.) He discussed the need for training materials and strategies for each of these problems, particularly for training of basic health workers (CHWs, dais) and for working out supply logistics, (e.g. getting the ORS into homes). In a pilot program in Haryana the technologies were proven successful by the substantial reductions obtained in mortality from these three diseases. (There have also been successful experiments in other parts of the world). With these three interventions infant mortality could be reduced (from the present 130/1000) to 60. There remains a need to do operations research to put the technologies into the primary health care system.

Dr. Vijay Kumar suggested that the area projects assisted by various donor agencies could take up this program, trying to expand the pilot success to about 20-25 districts in the country.

The ensuing discussion dealt with a number of specific points, among which the most important were :

1) The need for the health service system to undertake operations research itself and 'manage' a specific health problem (V. Kumar).

2) The need for cost-effectiveness studies of specific interventions (Cylke).

3) The need to make simple technologies available at low cost at the village level (Antia).

4) The question of legal permission for VHWs to give injections (following training and operations research on a larg scale) (Antia, O'Byrne).

5) Participation of people in research efforts (Kimati, Arole, V. Kumar).

Prof. Ashok Subramanian, Public Systems Group, Indian Institute of Management, Ahmedabad, spoke next on management training (he prefers "education") for rural health. The need formanagement stems from the poor functioning and utilization of health services. An appreciation of this need specifically for training of doctors - is (or can be) created at three junctures : (1) during medical education, particularly in the rural posting, (2) at the point when the PHC doctor realizes his need for management assistance to run the PHC, and (3) through professional associations. However, to institute management training in the government system requires "a climate of learning and problem-solving rather than fault finding". There are good "pilot projects" in government also because of good personnel.

There is a need to create a variety of institutions at the regional level to provide professional management assistance. Faculty of management training institutes must have field experience to be credible and training must be linked with practice. Materials can be developed from field experience. Training institutions must also play a role in finding out management problems as "the system" may not recognize thisneed.

Three areas of knowledge which are imported by management "education" are :(1) organization processes, roles and responsibilities, (2) systems development, and (3) prioritizing problems and formulating strategies. To put this knowledge into practice, trainees are exposed to "action planning" where they apply their learning to their own situations. However, there is a need to find ways to decentralize research and training "on the job".

4) The question of legal permission for VHWs to give [illegible] (following training and operations research on [illegible] scale) (Amrit, Gidwani).

5) Participation of people in [illegible] (Rao, Kumar, V. Kumar).

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Management must be concerned with finding ways to make the system accountable at the local level, down to the village level

Dr. Ruth Harnar addressed the issue of training nurses for rural health. She cited several problems : recruitment, placement and retention, administration, training and development of personnel. Nurses face a number of human (social) problems. They are loaded with tasks and under-supported bythe rest of the health system. Their training (in district/urban hospitals) has not been appropriate to the job they are asked to do in rural areas. They have little experience of rural problems and conditions. Dr. Harnar suggested ways to overcome some of these problems - locating ANM training schools in rural hospitals and alternating field and hospital training, orienting course content to community health work and problem solving, recruiting local women and posting them nearby. She listed several ways in which communities could be involved in this process : selection of village sites, assisting teachers, identifying problems, recruiting etc. The overall goal is to prepare nurses better for independent work in primary health care as members of the community.

The final discussion session centered on miscellaneous points:

1) The health service system must work with communities to help them get the knowledge they need to help themselves. Village level workers need the back up support of other members of the health team. (Subramanian, Harnar, Krishnamurthy).

2) Doctors need to be geared to community health work (including management) (Saigal).

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The final discussion session centered on nurse/midwife policy:

1) The health service system must work with communities to help them get the knowledge they need to help themselves. Village level workers need the back up support of other members of the health team. (Sister Marion, Burundi, Kirshnamurthy)

2) Doctors need to be geared to community health work (including management) (Sargol).

3) Objective evaluation of the effectiveness of a PHC is desirable and to make it accountable to the people one should educate them about the responsibilities of the health system. Health workers must be trained and supported appropriately (Antia, Saxena, Nanavaty, Walia).

4) The need to work out needs in the field not just to do studies in isolation. (Saigal).

Dr. Saxena summarized the foregoing session and the meeting was concluded.

RAPPORTEUR : Dr. Meera Chatterjee

INVITEES TO COLLOQUIUM
NOVEMBER 26, 1983

1.	Mr. Owen Cylke	Director, USAID
2.	Mr. C.R. Vaidyanathan	Secretary, MOHFW
3.	Dr. A. Zahra	WHO Program Coordinator
4.	Dr. Harcharan Singh	Health Advisor, Planning Commission
5.	Mr. Shahaji Bhondve	Village Headman, Jamkhed
6.	Dr. Pravin Visaria	Director, Gujarat Inst. of Area Planning
7.	Dr. N.H. Antia	Trustee, Foundation for Research in Community Medicine, Bombay
8.	Dr. D.B. Bisht	Director-General, D.G.H.S.
9.	Dr. Badri Saxena	Dy. Director General, I.C.M.R.
10.	Dr. R.C. Mahajan	Dept. of Parasitology, PGI, Chandigarh
11.	Dr. Vijay Kumar	Dept. of Comm. Med., PGI, Chandigarh
12.	Dr. Ashok Subramaniam	IIM, Ahmedabad
13.	Dr. Ruth Harnar	VHAI, Delhi
14.	Ms. Mira Chatterjee	Center for Policy Research
15.	Dr. M.D. Saigal	Addl. DGHS, MOHFW
16.	Dr. Somnath Roy	Director, NIHFW
17.	Mr. R.P. Kapur	Addl.Secy. & Commissioner, MOHFW
18.	Mr. Uma Shankar	Addl. Secretary (Health), MOHFW
19.	Mr. P. Dasgupta	Joint Secretary, MOHFW
20.	Mr. S.K. Sudhakar	Joint Secretary, MOHFW
21.	Dr. S.P. Jain	Secretary, Medical Council of India
22.	Ms. B. Storgaard	Danida
23.	Mr. C. Raleigh	ODA, Delhi
24.	Mr. Hugo Corovalan	UNFPA
25.	Dr. Lincoln Chen	Ford Foundation
26.	Dr. Saroj Pachauri	Ford Foundation
27.	Dr. Nancy Sadka	UNICEF
28.	Mr. C.R. Krishnamurthy	WHO
29.	Mr. M. Nanavaty	Consultant
30.	Dr. Donald Minkler	IRHP Mid-term Project Eval.Team
31.	Ms. Anne Aarnes	"
32.	Dr. Mabelle Arole	"
33.	Mr. P.E. Balakrishnan	"
34.	Dr. Margaret Mamgain	"
35.	Dr. Michael O'Byrne	"
36.	Dr. James Palmore	"
37.	Dr. Jerry Russell	"
38.	Dr. Inderjit Walia	"
39.	Dr. R.M. Brown	DD, USAID
40.	Dr. Dennis Johnsen	SCI
41.	Mr. M. Jordan	POP
42.	Dr. W.B.R. Beasley	HN
43.	Mr. J. Rogosch	HN
44.	Dr. Saramma Thomas Mathai	HN
45.	Ms. Mary Ann Anderson	HN
46.	Ms. Michelle Kirby	HN
47.	Dr. P. Diesh	HN
48.	Dr. V. Moses	HN